Task Force For Selecting New Children's Instruments

Synopsis of January 9, 2001 Meeting

A meeting of the Task Force for Selecting New Children's Performance Outcome Instruments was held on Tuesday, January 9, 2001, at the Sacramento Airport Host Hotel. The topics of discussion and the actions that were recommended are highlighted below.

- **Welcoming Remarks and Introductions** – Jim Higgins, Department of Mental Health (DMH), led introductions and reviewed the agenda. Representatives from the following counties were present: Astrid Beigel (Los Angeles County), Uma Zykofsky and Sue Farley (Sacramento County), Kim Suderman and Rudy Arrieta (San Joaquin County), Jan Perez and Harry Leonard (San Mateo County), and Karen Brown (Sutter-Yuba County). Zoey Todd represented the California Mental Health Planning Council. Emily Harris represented the UC Davis Division of Child Psychiatry. Dave Neilson and Luis Zanartu represented the DMH Children's Systems of Care. Brenda Golladay represented the DMH Research and Performance Outcomes Development (RPOD).

- **Review Preliminary Data Analyses –** After reviewing a preliminary descriptive analysis of the data collected from the Client Information/Risk Factor Assessment, as well as the Client Living Environment and Stability Profile (CLESP), Task Force members felt that the results should be carefully approached. In the future, pilot study data analyses should be considered with respect to the age of the child/youth and even the definition of the variable. The interpretation should be distributed so that certain groups examine specific aspects of the data (e.g., a focus on the Child Protective Services data). One method of doing this would be for DMH to give the counties all of the data stripped of the county and client identifiers (interested counties could also get their own data). This would not only allow counties to gauge their resources to outcomes, but also to describe their population and look at correlations. This is important at the local level and at the state level. For the next meeting, Task Force members requested that DMH prepare an analysis that shows how the pilot study data compares to the general population. Another point that was made involved the reporting of "unknown" since there is a difference between not being able to find out versus not having enough time to find out. The pilot study design addresses this point in the sense that clinicians have adequate time (sixty days) to complete the risk factor assessment.

  Discussion arose surrounding the point of collecting the risk factor information. This information is being collected in order to show that children with certain risk factors (or clusters of risk factors) are prone to have certain outcomes. It is an attempt to look for partner guidelines that might drive the service delivery system. In mental health agencies, many of these have been identified, but it is also useful on a system level. As a side note, it was determined that it is important to develop definitions for each of the risk factors, making sure to include clinicians in the process. This was tabled for afternoon discussion.

- **Review Draft Sample Survey for Time it Takes to Administer the Pilot Instruments –** The following revisions were made to the draft of the instrument developed to collect information on the time it takes to complete the instruments:

  - The question, "In what context was the <instrument> completed?" was reworded to ask, "Where was the <instrument> completed?"

  - Rather than providing bubbles to mark how many minutes it took to complete the form, boxes will be provided that allow the respondent to write in the time.

- **Youth Services Survey for Families (YSS-F) Update** – A complete data set for the Youth Satisfaction Survey for Families is expected by February 2001. Colorado and Kentucky are still collecting data. Certain notable information provided to DMH by Molly Brunk in regards to the Virginia State data included:

  A) When analyzing the data, it is critical to compare methods (e.g., point of service). If a client is still receiving services, then rating tends to be higher. If a client is not receiving services (e.g., follow-up), then the rating tends to be lower.

  B) Medicade clients tend to report higher levels of satisfaction. This is likely due to the fact that Medicade covers a fuller range of services than traditional insurance.

  C) There was a 34% response rate after two mail-outs. The second mail-out received the highest response.

  D) The sample was representative at the state level, but not at the community level.

  E) For the Youth Satisfaction Survey (YSS), filled out by adolescents, rating tends to be lower. It is important to compare adolescents to adolescents, not adults.

  In discussing the satisfaction survey, the question arose as to whether or not the method of administration would influence the responses gathered in the pilot study. Initially it was suggested that it might be useful to have an identifier to indicate the method of administration, but ultimately it was decided that this was not necessary for system level measurement.

  Another thought was to make the adolescent survey available in addition to the parent survey for the purpose of empowering the youth clients. Also, members questioned whether or not the satisfaction survey should be linked to other tools such as the Ohio Scales. Because the intent of the design is to capture a point-in-time picture of the system as a whole, it is not necessary to collect the data on an individual level. It was decided that it should be distributed in the serving clinics, using parent partners, if necessary.

- **Pre-Pilot County Report** – Participating counties present at the Task Force meeting presented an update of their current implementation status:

  Kern: A total of fifteen (15) surveys have been completed, most from one site with three teams. Although the holidays slowed the process, the response from the clinical staff thus far is positive and everything seems to be moving smoothly.

  Sutter-Yuba: Response from the clinical staff is still positive, although there was concern raised regarding item #3 on the Spanish translation of the Ohio Scales. There have been some problems with clinicians remembering which forms they are responsible for filling out. Some clinicians were baffled at the Ohio Scale "Agency Worker

Rating" since they are used to being referred to as clinicians and not agency workers. Participating clinicians have been advised that they are to complete the Ohio Scale "Agency Worker Rating" instrument.

Stanislaus: Because of the holidays, Stanislaus had a difficult time getting going, but administration of the instruments is scheduled to begin by January 12, 2001.

- **Protocol Instrument Issues** –

Ohio Scales

Because of difficulties that have risen dealing with some items not being age appropriate and/or lacking cultural sensitivity, revisions have been made to the Ohio Scales. With the permission of Benjamin Ogles, a new response option, "Does Not Apply", was added to Section I, Functioning, on both the English and Spanish versions of the Ohio Scales. To validate the reliability of this revision, DMH will do a study in which both forms (before and after the changes) will be administered to a small sample of clients. Task Force members also suggested that it might also be helpful incorporate into the instructions a sentence that explains the fact that some of the items pertain to adolescents. This alteration would need to be approved by Benjamin Ogles.

To address the question raised at the last meeting, DMH contacted Benjamin Ogles to get information regarding the scoring algorithm for the Ohio Scales. In particular, Task Force members were interested in how many items could be missing before the scale becomes invalid. The following is Dr. Ogle's response:

A) Functioning
If four or fewer items are missing, then add up and total the items. Those items that are missing should be counted as a score of "3", or "OK".

B) Problem Severity
If four or fewer items are missing, then add up and total the items. Those items that are missing should be counted as a score of "0", or "Not a Problem".

NOTE: If five or more of the items are missing , then do not score the instrument as it is 25% incomplete.

This information does not appear in the Ohio Scales Users or Technical Manuals, but it does appear in the Ohio State Department of Mental Health documents.

An important concern has been raised concerning the Spanish translation of item #3 on Section I of the Ohio Scales. The translation, "Tiene un novio o novia", specifically asks the respondent if the child/youth has a boyfriend or girlfriend. The original item asks, "Dating or developing relationships with boyfriends or girlfriends". Since these are two very different question, members asserted that the Spanish translation be corrected. Two of the Spanish-speaking Task Force members volunteered to correctly translate the item.

Other concerns mentioned regarding the Ohio Scales had to do with the fact that some of the questions ask two things (e.g., Question #35, "Feeling lonely and having no friends"). Task Force members felt that items such as these should be separated and split into two items.

- **Development of a Reference Sheet for the Client Information/Risk Factor Assessment Form –** The following operational definitions were developed for items on the Client Information/Risk Factor Assessment form:

  Q: What agencies are currently involved with this child?
  Child Protective Services: e.g., open case, receiving services from, preventative services, interventions; touched by the system.
  Regional Center: state agency that provides special services for developmentally delayed children; five different criteria and legal definition.

  Q: Do any of the following characteristics apply to the child's biological parent and/or caregiver?
  Physical Illness: Ongoing health condition that interferes with the parent's ability to care for the child.
  Law Violations: Convicted of a felony or misdemeanor (other than minor traffic violations).
  Poverty: Use the federal definition as reflected in the county's local Uniform Method of Determining Ability to Pay (UMDAP) requirements.
  Other Kids in Foster Care: refers to the biological parent/current caregiver having any of their own children placed outside of their care.

  Q: Do any of the following characteristics apply to the child?
  Chronic Physical Illness: Illness that warrants medical attention (whether or not they are receiving it).
  Law Violations: As a result of law violations, has the child had any contact or involvement with law enforcement.
  Learning Disability: School has identified that the child has a learning disability, as identified by Special Education, but may not necessarily receiving special education services.
  Physical and Sexual Abuse: Suspected physical and/or sexual abuse that has been reported or verified.
  Sexual Perpetrator: The child has been verified or reported to having committed a sexual offense.
  Exposure to Violence: The child has witnessed violence in the family, extended family, neighborhood or schools (other than domestic violence).
  Domestic Violence: The child has witnessed or been exposed to violence against or by a parents/caregivers/partners.
  Neglect: Reported or verified neglect.

- **Topics To Be Discussed at the Next Children's Task Force Meeting**

  - ✓ Report on Pilot County Progress
    - Discuss Protocol/Instrument Issues
  - ✓ Update on the Client Identification/Risk Factor Assessment and CLESP Analyses
  - ✓ Review CAFAS/Ohio Scales Agency Worker Correlation Data Results
  - ✓ Youth Services Survey for Families (YSS-F) Update – Virginia Report
  - ✓ Review Draft Reference Form for the Client Identification/Risk Factor Assessment Instrument
  - ✓ Approve Finalized Version of the Survey for the Time it Takes to Administer the Pilot Instruments

- Next Meeting - **Sacramento Airport Host Hotel, American Room**
  February 6, 2001
  10:00 AM – 3:00 PM